U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 11 October 2005

CASE NO.: 2003-BLA-6509

In the Matter of:

FRANK B. GRUBB
Claimant

v.

VALLEY CAMP COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

APPEARANCES:

Sandra M. Fogel, Esq.
For the Claimant

Mary Rich Maloy, Esq.
For the Employer

Before: DANIEL L. LELAND
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A formal hearing was held in Charleston, West Virginia on May 17, 2005, at which all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20 Code of Federal Regulations. Regulation section numbers mentioned in the Decision and Order refer to sections of that Title. At the hearing, Director's exhibits (DX) 1-41[1], Claimant's exhibits (CX) 1-3, and Employer's exhibits (EX) 1, 2, and 5 were admitted into evidence. Claimant and Employer submitted closing briefs.

ISSUES

I. Existence of pneumoconiosis.

II. Causal relationship of pneumoconiosis and coal mine employment.

III. Existence of total disability.

IV. Causation of total disability.

FINDINGS OF FACT AND CONCLUSIONS OF LAW[2]

Procedural History

Frank R. Grubb (Claimant or miner) filed his first claim for benefits on February 5, 2001. (DX 2). The district director denied benefits on May 14, 2002, because the evidence did not establish that the miner has pneumoconiosis. (DX 24). On July 19, 2002, Claimant filed a request for modification and submitted additional x-ray evidence to establish that he has pneumoconiosis. (DX 26). The district director denied the request for modification on May 7, 2003. (DX 30). Claimant requested a hearing and the case was referred to the Office of Administrative Law Judges on August 19, 2003. (DX 31, 37).

Background

Claimant was born on March 26, 1935, and has one dependent, his wife, Rhoda. (DX 2; TR 19). Claimant worked in coal mines from 1956 to 1982; he only worked underground for one year. (TR 20-23).[3] Claimant's last job was as a dozer operator. Claimant testified that he operated the dozer, shoveled coal, and shoveled rocks as a part of his job. (TR 23). Claimant testified that he would have to get in and out of the dozer cab ten times per day. (TR 24). He

[1] At the hearing, I excluded Dr. Cappiello's x-ray interpretation at DX 26 and Drs. Spitz and Meyer's x-ray interpretations at DX 29. (TR 5-6).

[2] The following abbreviations have been used in this decision and order: TR = transcript of hearing, BCR = board-certified radiologist, B = B-reader.

[3] Based on claimant's Social Security records at DX 4, I credit him with twenty five years of coal mine employment.

testified that the hardest part of his job was cleaning the tracks, which required the use of a shovel. (TR 25). Claimant testified that it would take thirty to forty minutes to clean the tracks, and he would clean the tracks once per day. (TR 25-26).

Claimant testified that his breathing problems began after his 1982 retirement. (TR 27). Claimant has been prescribed an inhaler, which he uses twice per day, nebulizer treatment, which he uses two to three times per day, and oxygen to treat his breathing problems. (TR 27-29). Claimant spends his days lying in bed. (TR 29). He testified that he started smoking cigarettes at age fifteen or sixteen years, and he started to smoke cigarettes regularly in 1957. (TR 30). Claimant used to smoke one to one and one-half packs of cigarettes per day, but he cut down to one-half pack of cigarettes per day in 1995. Claimant quit smoking cigarettes on 2001. (TR 31).

Medical Evidence

Chest x-rays

Exhibit	**Date**	**Physician/Qualifications**	**Interpretation**
DX 15	6/5/01	Patel, BCR, B	Negative for pneumoconiosis
DX 16	6/5/01	Binns, BCR, B	Quality 1
DX 26	6/5/01	Ahmed, BCR, B	1/1, s/t
DX 29	6/5/01	Wiot, BCR, B	Negative for pneumoconiosis
DX 17	10/17/01	Willis, BCR, B	0/1, s/s
DX 37	10/17/01	Wheeler, BCR, B[4]	Negative for pneumoconiosis
CX 1	10/17/01	Alexander, BCR, B	1/0, p/q

[4] The B-reader certificate attached to Dr. Wheeler's x-ray interpretation has expired. An administrative law judge may take judicial notice of the qualifications of a physician in an official publication. *Pruitt v. Amax Coal Co.*, 7 B.L.R. 1-544, 1-546 (1984). The NIOSH B-reader list is an official publication that includes a listing of all of the physicians who have been certified as B-readers. I take judicial notice of the NIOSH B-reader list, which indicates that Dr. Wheeler was a certified B-reader on December 5, 2001, the date of his interpretation of the October 17, 2001 x-ray.

Pulmonary Function Studies

Exhibit	Date	Height	Age	FEV1	FVC	MVV
EX 5, Depo. Exhibit 3	2/24/82	72"	47	2.65	3.77	125
DX 11	6/5/01	70"	66	1.21 1.17*	2.08 2.39*	32 26*
DX 17	10/17/01	71"	66	1.11 0.99*	2.05 1.89*	30 ---*

* post-bronchodilator

Dr. Dominic Gaziano found the June 5, 2001 ventilatory study to be acceptable on December 10, 2001. (DX 12).

Blood Gas Studies

Exhibit	Date	PCO2	PO2
DX 10	6/5/01	63	48
DX 17	10/17/01	68	48

Medical Reports

Claimant was examined by Dr. D.L. Rasmussen on June 5, 2001. (DX 9). Dr. Rasmussen is a board-certified internist. (CX 3). Dr. Rasmussen noted that Claimant started smoking cigarettes in 1952, and that he continues to smoke one to one and one-half packs of cigarettes per day. Claimant complained of wheezing with colds, dyspnea for six to seven years, orthopnea, and ankle adema. The lung examination revealed moderately to markedly reduced breath sounds. The chest x-ray did not reveal any parenchymal opacities. The pulmonary function study revealed a severe, essentially irreversible obstructive ventilatory impairment. The arterial blood gas test revealed uncompensated respiratory acidosis. The diffusion capacity was minimally reduced. Dr. Rasmussen diagnosed chronic obstructive pulmonary disease/emphysema based on the miner's chronic productive cough, airflow obstruction, and reduced diffusion capacity. Dr. Rasmussen opined that the chronic obstructive pulmonary disease/emphysema was due to coal dust exposure and cigarette smoking. Dr. Rasmussen concluded that Claimant does not have the pulmonary capacity to perform his last coal mine job based on his marked loss of lung functioning. Dr. Rasmussen stated that coal dust exposure and cigarette smoking are contributory factors of Claimant's impairment. Dr. Rasmussen opined that coal dust exposure was a significant contributory factor because epidemiologic studies indicate that coal miners lose significant ventilatory capacity and may become disabled as a result of coal dust exposure in the absence of x-ray changes.

Dr. Robert J. Crisalli, a board-certified pulmonologist, examined Claimant on October 17, 2001. (DX 17). Dr. Crisalli noted that Claimant smoked one pack of cigarettes per day for

forty-four years, and that he currently smokes one-half pack of cigarettes per day. Dr. Crisalli noted that Claimant uses oxygen twenty-four hours a day, except when he is smoking cigarettes. The miner's complaints were: dyspnea, productive cough for years, and ankle adema. The lung examination was normal. The pulmonary function study revealed a severe expiratory airflow obstruction and severe air trapping. There was no restrictive defect and no improvement post-bronchodilator. Dr. Crisalli noted that only one of the diffusion efforts met validity criteria and that reproducibility was not possible. The arterial blood gas test revealed hypoxemia with respiratory acidosis. Dr. Crisalli concluded that there was insufficient evidence to diagnose coal workers' pneumoconiosis or any chronic lung disorder due to coal dust exposure. Dr. Crisalli diagnosed chronic obstructive pulmonary disease with components of emphysema and chronic bronchitis, chronic respiratory insufficiency based on hypoxemia and respiratory acidosis, and cor pulmonale based on the lower extremity edema, hypoxemia, and polycythemia. Dr. Crisalli concluded that Claimant has a severe, totally disabling pulmonary impairment. He opined that Claimant's impairment is due entirely to cigarette smoking-related emphysema and chronic bronchitis, which have led to chronic respiratory insufficiency. Dr. Crisalli stated that the miner's degree of air trapping is characteristic of an individual with emphysema secondary to cigarette smoking.

Dr. James R. Castle, a board-certified pulmonologist, reviewed the medical evidence and his opinions are in a report dated September 20, 2003. (EX 2). Dr. Castle concluded that the miner does not have coal workers' pneumoconiosis, but rather attributed his pulmonary impairment to cigarette smoking and obesity. First, Dr. Castle stated that Claimant has not consistently demonstrated physical findings indicating the presence of an interstitial pulmonary process. Dr. Castle noted that the presence of diminished breath sounds on numerous occasions is consistent with a significant obstructive airway disease. Second, Dr. Castle stated that the irregular opacities found in the mid and lower lung zones on the x-rays are typical of heavy tobacco abusers and significantly obese individuals, but are not findings that one would expect to find with pneumoconiosis. He opined that the pleural thickening noted on the x-rays is more likely subpleural fat than true pleural thickening. Third, Dr. Castle explained that the miner's severe obstruction without bronchodilator improvement, significant air trapping with reduction in diffusing capacity, and essentially normal DL/VA are typical changes caused by tobacco smoke-induced chronic airway obstruction. He stated that pneumoconiosis usually causes a mild, irreversible, mixed degree of airway obstruction and restriction. Fourth, Dr. Castle stated that Claimant's severe degree of hypoxemia and very significant degree of hypercapnia are typical of cigarette smoking-induced chronic obstructive pulmonary disease, but are not findings associated with pneumoconiosis. Thus, Dr. Castle concluded that Claimant does not have the physical, radiographic, physiological, or arterial blood gas findings of pneumoconiosis. Dr. Castle opined that Claimant is totally disabled due to his pulmonary impairment, which is due to tobacco smoke-induced chronic obstructive pulmonary disease with respiratory insufficiency. Dr. Castle stated that obesity may have also contributed to his impairment.

Dr. Castle was deposed on March 9, 2004. (EX 5). Dr. Castle testified that Claimant does not have medical or legal pneumoconiosis. (Id at 24). However, Dr. Castle did find that Claimant is totally disabled from his last coal mine job. (Id at 23). Dr. Castle testified that Claimant's carboxyhemoglobin levels at the time of Drs. Rasmussen and Crisalli's examinations indicate that he was smoking one to two packs of cigarettes per day. (Id at 12). Dr. Castle

explained that the arterial blood gas tests revealed acidosis (the lungs are not adequately getting rid of carbon dioxide), which is directly related to tobacco use and obesity. (Id at 15). Dr. Castle also explained that Claimant's 2001 pulmonary function study results are significantly worse than his 1982 results, and opined that the changes are due solely to cigarette smoking because Claimant was no longer exposed to coal dust. *Id.* Dr. Castle testified that "exacerbation of COPD" does not occur with coal workers' pneumoconiosis, and testified that an individual with pneumoconiosis would not respond to drugs. (Id at 17-18). Finally, Dr. Castle disagreed with Dr. Rasmussen's opinion that coal dust exposure contributed to Claimant's pulmonary impairment, and noted that Dr. Rasmussen did not consider what role obesity played in his impairment. (Id at 21).

Dr. Robert A.C. Cohen, a board-certified pulmonologist, reviewed the medical evidence and his conclusions are in a report dated March 11, 2005. (CX 2). Dr. Cohen concluded that Claimant has coal workers' pneumoconiosis based on twenty-seven years of underground coal mine employment, symptoms consistent with chronic lung disease (cough, sputum production, dyspnea, and wheezing), physical examinations in the last few years consistently showing signs of chronic lung disease (decreased breath sounds, wheezes, prolonged expiration), pulmonary function studies revealing severe obstructive lung disease with no reversibility, abnormal diffusion capacity, and abnormal gas exchange. Dr. Cohen stated that Claimant's severe obstructive lung disease with reduced diffusing capacity and hypoxemia is severe enough to preclude him from engaging in the physical exertion of his last coal mine job. Dr. Cohen concluded that Claimant's long-term exposure to coal dust is a significant contributing cause of his pulmonary impairment. Dr. Cohen also found that tobacco smoking was a contributing factor of his impairment, as the objective test results are consistent with both coal dust exposure and cigarette smoking. Dr. Cohen opined that Claimant's impairment is not due to obesity because obesity does not cause a severe obstructive lung disease; however, he noted that obesity may contribute to Claimant's elevated PCO2.

Hospitalization Records

The record includes hospitalization records from Charleston Area Medical Center. (EX 1). Claimant was hospitalized from April 3-7, 2001 for respiratory failure due to exacerbation of chronic obstructive pulmonary disease. On April 3, 2001, Dr. Nilima Bhirud, the emergency room physician, noted that Claimant complained of a chronic cough, but no sputum production. He noted severely decreased air entry on both sides and bilateral wheezing on lung examination. Claimant went to the emergency room on August 2, 2001, and was diagnosed with exacerbation of chronic obstructive pulmonary disease. On that date, Claimant denied a chronic productive cough. The lung examination revealed bilateral severely decreased air entry and scattered wheezing. Claimant was hospitalized from December 13-18, 2001 for chronic respiratory failure and exacerbation of chronic obstructive pulmonary disease. On December 13, 2001, Dr. Bhirud noted a slight nonproductive cough and distant breath sounds on lung examination. It was also noted that Claimant continues to smoke cigarettes.

Conclusions of Law

Within one year of a denial of benefits, a claimant may request modification based on a mistake in a determination of fact or a change in conditions. § 725.310. In determining whether there has been a change in conditions or mistake of fact, the administrative law judge must assess the newly submitted evidence and consider it in conjunction with the previously submitted evidence to determine if the weight of the evidence is sufficient to demonstrate an element or elements of entitlement which were previously adjudicated against the claimant. *Jessee v. Director,* OWCP, 5 F.3d 723 (4th Cir. 1993); *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994). In the Proposed Decision and Order – Denial of Benefits issued May 14, 2002, the district director found that Claimant is totally disabled, but that the evidence did not establish that he has pneumoconiosis.

A finding of the existence of pneumoconiosis may be made based on chest x-rays, autopsies or biopsies, the presumptions in §§ 718.304, 718.305, or 718.306, and the reasoned medical opinion of a physician that the miner has pneumoconiosis as defined in § 718.201.[5] § 718.202(a)(1)-(4). All types of relevant evidence must be weighed to determine if the miner has pneumoconiosis. *Island Coal Creek Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

The record contains seven interpretations of two chest x-rays. Of the seven interpretations, two are positive for pneumoconiosis, four are negative for pneumoconiosis, and one interpretation only addresses the quality of the x-ray film. In evaluating the chest x-ray interpretations, the qualifications of the physicians reading the x-rays must be taken into account. § 718.202(a)(1). The x-ray interpretations of physicians who are board-certified radiologists and B-readers are entitled to the greatest weight. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). All of the x-ray interpretations are by dually-qualified physicians. In his closing brief, Claimant argues that Dr. Patel's x-ray interpretation should be interpreted as positive for pneumoconiosis because his narrative report refers twice to "obvious small opacities in the lungs" (DX 14), even though he marked the ILO classification form as negative for pneumoconiosis. *See* DX 15; *Claimant's Closing Brief* at 6-7. I disagree. According to § 718.102(b), "a chest x-ray to establish the existence of pneumoconiosis shall be classified as Category 1, 2, 3, A, B, or C, according to the International Labour Organization Union Internationale Contra Cancer/Cincinnati (1971) International Classification of Radiographs of the Pneumoconioses (ILO-U/C 1971), or subsequent revisions thereof." Dr. Patel clearly indicated on his ILO classification form that he interpreted the June 5, 2001 x-ray as negative for pneumoconiosis. In fact, Dr. Patel initially marked the "yes" box to the question "any parenchymal abnormalities consistent with pneumoconiosis?," but then used white-out to remove the X in the "yes" box and marked the "no" box. Further, Dr. Patel's narrative report does not comply with the ILO-UICC classification system, as he does not indicate the profusion or location of the small opacities. I find that Dr. Patel's vague references to small opacities in his narrative report do not override his negative interpretation of the x-ray on the ILO classification

[5] Pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment, and it includes both medical, or clinical, pneumoconiosis and statutory, or legal, pneumoconiosis.

form. As only two of the six x-ray interpretations are positive for pneumoconiosis, I find that a preponderance of the x-ray evidence does not establish the existence of pneumoconiosis.

There is no biopsy evidence and the enumerated presumptions are not applicable to this claim.

The record includes the medical opinions of four physicians. Dr. Cohen diagnosed coal workers' pneumoconiosis. Dr. Rasmussen diagnosed chronic obstructive pulmonary disease/emphysema due to coal dust exposure and cigarette smoking. Dr. Crisalli diagnosed chronic obstructive pulmonary disease with components of emphysema and chronic bronchitis due solely to cigarette smoking. Dr. Castle diagnosed chronic obstructive pulmonary disease due to cigarette smoking.

It is well-settled that pneumoconiosis has both a medical and legal definition. § 718.201(a); *see also Clinchfield Coal Co. v. Fuller*, 180 F.3d 622, 625 (4th Cir. 1999); *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821 (4th Cir. 1995). Medical pneumoconiosis is a lung disease diagnosed by x-ray opacities indicating nodular lesions on the lungs. *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976); *see also* § 718.201(a)(1). Legal pneumoconiosis is a broader category of diseases, and includes "any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." § 718.201(a)(2); *see also Hobbs*, 45 F.3d at 821. Section 718.201(b) defines "arising out of coal mine employment" as any chronic respiratory or pulmonary impairment "significantly related to, or substantially aggravated by, [coal] dust exposure." Evidence that does not establish medical pneumoconiosis, i.e., an x-ray read as negative for pneumoconiosis, is not evidence against establishing legal pneumoconiosis. *Hobbs*, 45 F.3d at 821.

Dr. Rasmussen diagnosed chronic obstructive pulmonary disease/emphysema based on Claimant's chronic productive cough, airflow obstruction, and reduced diffusion capacity. Dr. Rasmussen opined that coal dust exposure is a significant contributory cause of Claimant's chronic obstructive pulmonary disease and emphysema because epidemiological studies have correlated coal dust exposure with chronic obstructive lung disease. Dr. Rasmussen's diagnosis based on a chronic productive cough is not consistent with his examination of Claimant, as he noted that Claimant did not complain of a cough or sputum production. (DX 9 at 2, 5). Also, Dr. Rasmussen's reference to epidemiological studies only demonstrates that coal dust exposure can cause obstructive lung disease, not that it caused Claimant's chronic obstructive pulmonary disease. Dr. Rasmussen provides no explanation as to how he determined that Claimant's obstructive lung disease was significantly due to coal dust exposure rather than his fifty years of cigarette smoking. For these reasons, I find that Dr. Rasmussen's opinion is poorly reasoned and accord it little weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987).

Dr. Cohen diagnosed coal workers' pneumoconiosis based on Claimant's twenty-seven years of underground coal mine employment and his symptoms, physical examinations, and objective test findings that are consistent with a chronic lung disease. Dr. Cohen opined that coal dust exposure is a significant contributory factor of Claimant's lung disease because epidemiological studies demonstrate a causal connection between coal dust exposure and obstructive lung disease. I find that Dr. Cohen's diagnosis of pneumoconiosis based on

Claimant's twenty-seven years of underground coal mine employment is not supported by the evidence, as Claimant testified that he only worked underground for one year. I also find that Dr. Cohen's lengthy discussion of epidemiological studies does not establish that coal dust exposure is the cause of Claimant's obstructive lung disease as the epidemiological studies only demonstrate that coal dust exposure can cause obstructive lung disease. As Dr. Cohen provides no other explanation for why Claimant's obstructive lung disease is due to coal dust exposure, I find that his opinion is not sufficient to establish the existence of legal pneumoconiosis.

Drs. Crisalli and Castle concluded that Claimant's chronic obstructive pulmonary disease is due to his cigarette smoking. Dr. Castle also opined that Claimant's obesity may have contributed to his obstructive impairment. Dr. Crisalli explained that Claimant's degree of air trapping is characteristic of individuals with emphysema secondary to cigarette smoking. Dr. Castle explained that the irregular opacities in the mid to lower lung zones are typical of individuals that are heavy cigarette smokers or are significantly obese. Also, Dr. Castle explained that the results of the pulmonary function studies and arterial blood gas tests are typical of tobacco smoke-induced chronic airway obstruction, but are not findings associated with coal workers' pneumoconiosis. I find that Drs. Crisalli and Castle's opinions are supported by the objective medical evidence. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90, n.1 (1986). I also find that their opinions are reasoned. Therefore, I accord great weight to the opinions of Drs. Crisalli and Castle.

After weighing all the physician opinion evidence, I find that Claimant has not established the existence of legal pneumoconiosis. As stated above, I am required under *Compton* to weigh all of the evidence together to determine if Claimant has established the existence of pneumoconiosis. 211 F.3d at 211. I previously found that the chest x-ray evidence did not establish the existence of medical pneumoconiosis. After weighing all of the evidence together, I find that Claimant has not established the existence of pneumoconiosis.

A miner shall be considered totally disabled if the irrebuttable presumption in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing the values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work. § 718.204(b)(2).

The record contains three pulmonary function studies. The pre-bronchodilator and the post-bronchodilator portions of the two 2001 pulmonary function studies produced qualifying values. I find that a preponderance of the pulmonary function study evidence establishes that Claimant is totally disabled.

The record contains two arterial blood gas tests. Both arterial blood gas tests produced qualifying values. I find that the blood gas test evidence establishes that Claimant is totally disabled.

Pursuant to § 718.204(b)(2)(iii), a miner is considered totally disabled where "the miner has pneumoconiosis and has been shown by the medical evidence to be suffering from cor pulmonale with right-sided congestive heart failure." Dr. Crisalli stated that the miner "likely" has cor pulmonale based on his lower extremity edema, hypoxemia, and polycythemia. (DX 17). However, as there is no evidence that the miner has right-sided congestive heart failure, I find that the evidence does not establish that Claimant is totally disabled under this subsection.

There are four physician opinions that address whether Claimant is totally disabled. Drs. Rasmussen, Cohen, Castle, and Crisalli found that Claimant is totally disabled from his pulmonary impairment and is unable to perform his last coal mine job. I find that their opinions are supported by the objective medical evidence. I also find that the opinions of Drs. Rasmussen, Cohen, Castle, and Crisalli are reasoned. Therefore, I find that the physician opinion evidence establishes that Claimant is totally disabled. After weighing all of the evidence, I find that Claimant is totally disabled.

After reviewing all of the evidence, I find that Claimant has failed to establish a change in conditions or a mistake in a determination of fact warranting a finding that he has pneumoconiosis. As Claimant has not established that he has pneumoconiosis, he cannot establish that he is totally disabled due to pneumoconiosis. Therefore, his claim will be denied. Claimant's counsel is precluded from receiving a fee for her legal work on this case.

ORDER

IT IS ORDERED THAT the claim of Frank R. Grubb is DENIED.

A

DANIEL L. LELAND
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).